TREATMENT ASSISTANCE PROGRAM
INDIVIDUAL RENEWAL APPLICATION

SECTION A – AGENCY/PRACTICE INFORMATION

AGENCY/PRACTICE NAME:_____

FEDERAL TAX ID:_____

ADDRESS:_____
city state zip

PHONE:_____ FAX:_____ E-mail:_____

PRINCIPLE NAME:_____

SECTION B – MINIMUM REQUIREMENTS

PROFESSIONAL LICENSES (Submit copies of all licenses):

LICENSE	LICENSE NUMBER	ISSUING BODY	DATE VALID THROUGH

TRAINING: Must have completed 12 hours of problem gambling specific training between February 1, 2006 and January 31, 2007. **Submit copies of certificates of completion for all training claimed**.

Title	Provider	Location	Date	Hours

SECTION C – PROGRAM INFORMATION

Respond to the following items. Responses should highlight any changes that have occurred to services offered, program design or anticipated changes over the course of the coming contract year. Information submitted under this section will be a significant consideration in the OPG determining the amount of funding potentially available to the applicant over the course of the contract year.

A. Describe any changes in the design of Treatment Assistance Program services at your agency/practice. Include information about changes or additions in locations where services will be delivered. Indicate any special or unique services that you or your agency will offer in the coming contract year.

B. Describe any staff changes that have occurred during the course of the current contract and any anticipated staff changes in the coming contract year.

C. Describe any barriers your agency/practice has encountered in providing problem gambling services and your efforts to overcome these barriers.

D. Describe how your agency/practice has historically received referrals for problem gambling services and any plans the agency has for maintaining, changing or improving the process in the coming contract year.

E. Submit professional liability insurance certificate documenting compliance with insurance requirements delineated in the Uniform Terms and Conditions.

SECTION D – CLINICAL SUPERVISION

If the individual is required to provide TAP services under clinical supervision (as delineated in Section 01 of TAP Provider Manual), the individual must indicate below who will be providing clinical supervision. Note: The individual providing supervision must be someone who is an OPG approved supervisor.

Name of Supervisor:_____ Phone #:_____

Address:_____ E-Mail:_____

I certify that the information provided on this form is true and correct. I will notify the Office of Problem Gambling Treatment Administrator of any additions/changes to the information.

_____ _____
Name (Please print) Title

_____ _____
Signature Date

Mail the complete application along with supporting documentation to:
Arizona Office of Problem Gambling
Attn: Treatment Administrator
202 East Earll, Suite 200
Phoenix, AZ 85012